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INTERNATIONAL HEALTH EMERGENCIES IN FAILED AND FAILING STATES

CHIARA GIORGETTI*

ABSTRACT

Global health emergencies, particularly those occurring in failed and failing States, can become threats to the stability of the international community. This Article assesses the international mechanisms available to respond to such emergencies. After defining global health emergencies, it discusses the implications of global outbreaks in failed and failing States. It then examines the role played by the World Health Organization in controlling global health emergencies, with particular reference to the newly amended 2005 International Health Regulations and the Global Outbreak Alert and Response Network. Finally, it explores the role of other international organizations, including the United Nations Children's Fund and the United Nations Office for the Coordination of Humanitarian Affairs, in addressing global health emergencies in failed or failing States. While no comprehensive and mandatory action plan exists to deal with global health emergencies, the tools developed by the World Health Organization and other international organizations are proving to be effective in dealing with global health emergencies so far. The lack of enforcement measures seems to be compensated by cooperation and voluntary actions by Member States, and significant non-State actor involvement. The lingering question is how to ensure that actions are taken in a timely and comprehensive manner in all global health emergencies.

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I. INTRODUCTION

Globalization and the spread of disease have made public health a matter of international concern. This is particularly true in situations of trans-boundary health emergencies, as demonstrated by the Severe Acute Respiratory Syndrome (SARS) and Ebola epidemics, and more recently by the cholera outbreak in post-earthquake Haiti and the outbreaks of H1N1 and H3N2 influenza.¹ Often, these emergencies cannot be addressed exclusively by one State, but must instead be addressed by the international community as a whole. The difficulties of successfully addressing trans-boundary health emergencies are compounded in situations of failed and failing States, where governments lack the power to control their territories and populations.²

This Article explores mechanisms available to respond to public health emergencies in failed and failing States, with the goal of assessing their effectiveness and identifying existing challenges. First, the Article defines health emergencies and State failure. Next, it examines the role played by the World Health Organization (WHO) in controlling global health emergencies, in particular through the International Health Regulations (IHR) and the Global Outbreak Alert and Response Network (GOARN). Finally, it discusses the role of other international organizations, including the United Nations Children's Fund (UNICEF) and the UN Office for the Coordination of Humanitarian Affairs (OCHA), in global health emergencies in failed or failing

1. See generally *Infectious Diseases*, WORLD TRADE ORG., http://who.int/topics/infectious_diseases/en/index.html (last visited June 15, 2013); *Influenza*, WORLD TRADE ORG., <http://www.wto.int/topics/influenza/en/> (last visited June 15, 2013). For SARS and H1N1, see *infra* Parts I and IV.A.2.

2. On the issue of state failure, see Chiara Giorgetti, *A Principled Approach to State Failure* (2009).

States. While no comprehensive and mandatory action plan exists to deal with global health emergencies, the tools developed by WHO and other international organizations have often proven to be effective in dealing with global health emergencies. The lack of binding enforcement measures seems to have been compensated by voluntary activities and cooperation by Member States and non-State actors. The question that still needs to be resolved, however, is how to ensure that actions are taken in a timely and comprehensive manner in all global health emergencies, even when the State at the center of the crisis is reluctant or unable to provide assistance. In these situations, IHR 2005 and GOARN can be used symbiotically to ensure a coordinated response to health emergencies in failed and failing States. In this way, WHO can play a fundamental role to ensure that health emergencies are detected and temporary recommendations are approved and implemented. It is important to ensure that WHO acts within its given powers and is provided the appropriate support and tools to carry out its mandate.

II. HEALTH EMERGENCIES AS GLOBAL SECURITY ISSUES

Health has become a central topic of international law. Its importance is recognized in several international and regional instruments, such as the Universal Declaration on Human Rights and the UN Convention on the Rights of the Child.³ The UN Charter cites the need to collaborate on health issues in several articles,⁴ and several interna-

3. See, e.g. Universal Declaration of Human Rights, G.A. Res. 217A (III) art. 25, U.N. Doc. A/810 at 71 (1948); International Covenant on Economic, Social and Cultural Rights art. 12, Dec. 16, 1966, 993 U.N.T.S. 3; Convention on the Rights of the Child art. 24, Nov. 20, 1989, 1577 U.N.T.S. 3; African Charter on Human and Peoples' Rights art. 16, June 27, 1981, 1520 U.N.T.S. 217; see also D. P. FIDLER, *INTERNATIONAL LAW AND PUBLIC HEALTH: MATERIALS ON AND ANALYSIS OF GLOBAL HEALTH JURISPRUDENCE* 277-331 (2000).

4. Article 13 states "The General Assembly shall initiate studies and make recommendations for the purpose of (b) promoting international co-operation in the . . . health fields". U.N. Charter art. 13 ¶ 1. Article 55 affirms "With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote: (b) solutions of international economics, social, health." *Id.* at art. 55. Article 57 further states: "The various specialized agencies, established by intergovernmental agreement and having wide international responsibilities, as defined in their basic instruments, in . . . health, and related fields, shall be brought into relationship with the United Nations in accordance with the provision of Article 63." *Id.* at art. 57 ¶ 1. Finally, Article 62 states "The Economic and Social Council may make or initiate studies and reports with respect to . . . health and related matters and may make recommendations with respect to any such matters to the General Assembly, to the Members of the United Nations, and to the specialized agencies concerned." *Id.* at art. 62 ¶ 1.

tional organizations now include health-related mandates, including WHO and UNICEF.⁵

Public health has increasingly become a global issue. Faster, easier, and cheaper transportation methods have resulted in a phenomenal increase in the movement of people and goods,⁶ and new conservation technologies have improved the international trade of perishable goods.⁷ These developments have made it easier for diseases to spread faster and to more distant locations.⁸ Indeed, easier movement of people and goods has facilitated not only the spread of infectious diseases, but also their emergence and reemergence in both humans and animals.⁹ Accordingly, global health¹⁰ has become an important concern for the international community. Globalization has, to a certain extent, undermined the ability of one State, acting alone, to protect its people from the spread of infectious diseases. As a result, it has become clear that only collective efforts can efficiently address

5. See *infra* Part IV. WHO "is the directing and coordinating authority for health within the United Nations system." See *About WHO*, WORLD TRADE ORG., <http://www.who.int/about/en/> (last visited June 15, 2013). Similarly, "improving the health of the world's children is a core UNICEF objective." *Focus Areas, Health*, UNICEF, <http://www.unicef.org/health/index.html> (last visited June 15, 2013).

6. For example, the World Trade Organization reports that the total value of exports increased to 18,323,000 million in 2012, from 2,034,000 million in 1980. See *International Trade and Market Access Data*, WORLD TRADE ORG., www.wto.org/statistics (last visited July 17, 2013). Similarly, the World Bank calculated that overnight visitors to France went from 60 million in 1995 to 81 million in 2011, and from 31 million to 46 million in Italy for the same period. *International Tourism, Number of Arrivals*, WORLD BANK, <http://data.worldbank.org/indicator/ST.INT.ARVL> (last visited June 15, 2013).

7. William Coyle et al., *Transportation Technology and the Rising Share of U.S. Perishable Food Trade*, in USDA ECONOMIC RESEARCH SERVICE, *CHANGING STRUCTURE OF GLOBAL FOOD CONSUMPTION AND TRADE* 31 (Anita Regmi ed., 2001) (explaining that by reducing delivery times, maintaining product quality, and reducing shipping costs, advances in transportation technology greatly facilitated trade of perishable food products).

8. Board of Global Health, *Impact of Globalization on Infectious Disease Emergence and Control: Exploring the Consequences and Opportunities* 21-48 (Knobler et al. eds., 2006).

9. See generally World Health Organization, *World Health Report 2008—A Safer Future: Global Public Health Security in the 21st Century* (2007), available at <http://www.who.int/whr/2007/en/index.html>.

10. The term 'global health' is preferred to 'international health' because, as Støre et al. explain, "global health" is rapidly overtaking the paradigm of 'international health' as the organizing principle for health cooperation. While the latter term focuses on relations among sovereign nations, the concept of global health encompasses health affairs within and among nations-states, as well as transnational challenges not defined by political borders. Global health thus recognizes multiple actor groups in the production of health, including but not limited to national government." J. G. Støre et al., *Health and Security for a Global Century*, in *GLOBAL HEALTH CHALLENGES FOR HUMAN SECURITY* 67-68 (L. Chen, et al. eds., 2003).

public health emergencies.

Deadly diseases like tuberculosis, malaria, and cholera are still widespread in many regions of the world.¹¹ Some of their pathogens are becoming drug-resistant, and thus more difficult to cure and isolate.¹² Some diseases are spreading into previously disease-free regions.¹³ Moreover, new infectious diseases, such as SARS and Ebola hemorrhagic fever,¹⁴ typically have trans-boundary effects, and thus can only be properly handled by the coordinated actions of multiple national and international actors. As global health expert Professor David Fidler concludes, "most public health experts agree that the distinction between national and international public health is no longer relevant because globalization has enabled pathogenic microbes to spread illness and death globally."¹⁵

Finally, the connection between national security and health has also become apparent.¹⁶ Significantly, States have begun to identify certain

11. See, e.g., *Global Health Observatory*, WORLD HEALTH ORG., <http://www.who.int/gho/malaria/en/index.html> (last visited Jun. 13, 2013) (globally, an estimated 3.3 billion people were at risk of malaria in 2011); see also WHO, *WORLD HEALTH STATISTICS 2012* 86-95 (2012) (providing statistics on selected infectious diseases), available at http://apps.who.int/iris/bitstream/10665/44844/1/9789241564441_eng.pdf.

12. See, e.g., *Multidrug-Resistant Tuberculosis (MDR-TB)*, WORLD HEALTH ORG., <http://www.who.int/tb/challenges/mdr/en/> (last visited Jun. 13, 2013) [hereinafter *Multidrug-Resistant Tuberculosis*] ("anti-tuberculosis drug resistance is a major public health problem that threatens progress made in TB care and control worldwide").

13. For example, cases of West Nile fever were recently diagnosed in New York City. Additionally, a new wave of tuberculosis—which is resistant to usual medications—has been found in Europe and in the United States. Denghi Hemorrhagic Fever is now considered endemic in fifty countries, a significant rise from the only nine countries considered endemic before 1970. See Gro Harlem Brundtland, Dir. Gen., WORLD HEALTH ORG., *Failed States and Global Security: How Health Can Contribute to a Safer World* 6 (Sept. 26, 2002), available at <http://www.brookings.edu/media/events/2002/09/26global-health>.

14. For a recent outbreak report, see Joe Sterling, *Ebola Outbreak Kills 10 in Congo*, CNN (Aug. 21, 2012), <http://www.cnn.com/2012/08/21/world/africa/congo-ebola>.

15. David D. Fidler, *The Globalisation of Public Health: Emerging Infectious Diseases and International Relations*, as quoted in FIDLER, *supra* note 3, at 16.

16. There is a new growing literature on this phenomenon. See, e.g., GLOBAL HEALTH CHALLENGES FOR HUMAN SECURITY (L. Chen et al. eds., 2003) (especially J. G. Støre et al., *Health and Security for a Global Century*; and D. L. Heymann, *Evolving Infectious Disease Threats to National and Global Security*; Jack C. Chow, *Health and International Security*, 19 WASH. Q. 2, 63-77 (1996); J. B. Tucker, & R. P. Kadlec, *Infectious Disease and National Security*, 29 STRATEGIC REV. 12-20 (2001). Heymann affirms: "This principle [of global public health security] has evolved in response to three concurrent trends. First, the highly publicized resurgence of the infectious disease threat illustrated the vulnerability of all nations to outbreaks and epidemics, often of new or unusual diseases. Second, the impact of AIDS on sub-Saharan Africa demonstrated the capacity of an emerging disease to destabilize a large geographical region in ways that undermine the very

diseases as national security threats and have developed measures to halt and control the spread of these diseases as part of their foreign policies.¹⁷ For example, in 2000, the Clinton administration for the first time declared AIDS a threat to the United States' national security and global stability¹⁸ and mandated the U.S. National Security Council to develop an appropriate response.¹⁹ President Obama shared the same understanding of the HIV/AIDS epidemic through a President's Emergency Plan for AIDS Relief.²⁰ UNAIDS, the joint UN program on

infrastructures needed for governance. Third, a reconsideration of the determinants of national security broadened the perception of what constitutes a security threat in the post-Cold War era, making space to accommodate infectious diseases—at least in their most internationally disruptive forms." Heymann, *supra*, at 106; see also Javed Siddiqi, *WORLD HEALTH AND WORLD POLITICS: THE WORLD HEALTH ORGANIZATION AND THE UN SYSTEM* (1995).

17. See *US: Aids is Security Threat*, BBC (May 1, 2000), <http://news.bbc.co.uk/1/hi/world/americas/731706.stm>; see also Barton Gellman, *AIDS Is Declared Threat to US National Security*, WASH. POST (Apr. 30, 2000), <http://www.commondreams.org/headlines/043000-02.htm>.

18. Heymann noted: "Several recent events suggest that emerging and epidemic-prone diseases are being taken seriously as a threat to national and global security. In an unprecedented step, a US government-supported study concluded in 1995 that emerging and reemerging infectious diseases, especially AIDS, constituted a national security threat and foreign policy challenge. In 1996, the US Department of Defense established the Global Emerging Infectious Surveillance and Response System, based on a network of domestic and overseas military laboratories, as an explicit acknowledgement that emerging disease can threaten military personnel and their families, can reduce military readiness, and present a risk to US national security. The threat posed by microbial agents to the security of the US was further acknowledged in 2000 by an equally unprecedented report from the US Central Intelligence Agency's National Intelligence Council. Citing the 'staggering' and 'destabilizing' number of deaths caused by AIDS in sub-Saharan Africa." David L. Heymann, *The Evolving Infectious Disease Threat: Implications for National and Global Security*, 4 J. HUMAN DEV. 2, 197 (2003); see also *HIV/AIDS as a Security Issue*, INT'L CRISIS GRP. (Jun. 19 2001), available at <http://www.crisisgroup.org//media/Files/africa/HIV-AIDS%20as%20a%20Security%20Issue.pdf>.

19. Following the same path, in his 2003 State of the Union Address, President Bush announced the Emergency Plan for AIDS Relief, a five-year, USD15 billion initiative. See *President Bush's Global Health Initiatives Are Saving Lives Around the World*, THE WHITE HOUSE, <http://georgewbush-whitehouse.archives.gov/infocus/bushrecord/factsheets/globalhealth.html> (last visited July 17, 2013). Also, the United States has created the role of United States Global AIDS Coordinator, presently occupied by Ambassador Eric Goosby. See *Ambassador Eric Goosby, Office of the Global AIDS Coordinator*, available at <http://www.pepfar.gov/documents/organization/125470.pdf>.

20. Lessons learned from the first decade of the President's Emergency Plan for AIDS Relief were assessed by the U.S. Global AIDS Ambassador in July 2012. See *U.S. Global AIDS Coordinator Ambassador Eric Goosby to Deliver Keynote Remarks at Health Affairs Briefing*, U.S. STATE DEP'T (July 9, 2012), <http://www.state.gov/r/pa/prs/ps/2012/07/194749.htm>.

HIV/AIDS, also advocates for a global response.²¹ Similarly and more broadly, in the 2005 UN World Summit Outcome Document, States recognized that “HIV/AIDS, malaria, tuberculosis and other infectious diseases pose severe risks for the entire world and serious challenges to the achievement of development goals.”²²

These legal, security, and policy developments have made it clear that public health has become a matter of international concern, one that often cannot be addressed exclusively by one State, but that requires action by the international community as a whole. Undoubtedly, there is currently a certain degree of collaboration among States on some public health matters. Several multilateral organizations exist at the regional level and collaborate on health issues.²³

Various international organizations, including WHO and UNICEF,²⁴ have also assumed coordination and facilitation roles in international public health matters. For example, epidemiologists from around the world meet periodically at the WHO Headquarters in Geneva to identify and recommend the most effective vaccine for the upcoming influenza season.²⁵ In addition, several international, national, and non-governmental organizations (NGOs) intervene in support of national health sectors during humanitarian crises—which often occur in

21. See *Getting to Zero: 2011-2015 Strategy*, JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS, at 8 (2010), available at http://www.unaids.org/en/media/unaids/contentassets/documents/unaidspublication/2010/jc2034_unaids_strategy_en.pdf.

22. 2005 World Summit Outcome, UN Doc. A/Res/60/1, Oct. 24, 2005, ¶ 57, available at <http://unpan1.un.org/intradoc/groups/public/documents/un/unpan021752.pdf>.

23. For example, the Pan American Health Organization. See PAN AMERICAN HEALTH ORGANIZATION, <http://www.paho.org/usa/> (last visited June 14, 2013).

24. UNICEF was established by a Resolution of the UN General Assembly on 11 December 1946. UNICEF is a semi-autonomous Agency of the UN system. It is headed by a 30-members Executive Board and an Executive Director elected by the UN Economic and Social Council. Its “purpose is to help developing countries improve the condition of their children and youths. It aids country projects, preferably those which form part of national programs of development.” It assists countries only at the request of their government. See Amos J. Paeslee, *UNICEF*, in *INTERNATIONAL GOVERNMENTAL ORGANIZATIONS*, Part I, Vol. II, 1398.

25. *Influenza Vaccine Viruses and Reagents*, WORLD HEALTH ORG., <http://www.who.int/influenza/vaccines/virus/en/> (last visited Jun. 14, 2013) (“Since 1973, WHO has provided formal recommendation for the composition of influenza vaccines based on the information provided by the WHO Global Influenza Surveillance Network (GISN), now the WHO Global Influenza Surveillance and Response System. High yield candidate vaccine viruses are developed by collaboration of laboratories involved in developing reassortants and WHO Collaborating Centres (CCs).”; see, e.g., *Recommended Composition of Influenza Virus Vaccines for Use in the 2013-14 Northern Hemisphere Influenza Season*, WORLD HEALTH ORG. (Feb. 21, 2013), http://www.who.int/influenza/vaccines/virus/recommendations/2013_14_north/en/index.html (recommending the content of the trivalent vaccine to be used in the 2013-14 influenza season in the northern hemisphere).

situations of conflict and State failure—and provide basic health care.²⁶

However, there are currently no binding general agreements that address the problem of global health emergencies, and no agreements on comprehensive plans or specific actions in situations of trans-boundary health emergencies.²⁷ Members of the international community realized that this lacuna was potentially deeply problematic during the game-changing 2002 SARS virus epidemic in China.

SARS, a serious form of highly contagious viral pneumonia, was first diagnosed in Southern China in 2003 and eventually spread to twenty-seven countries—including Hong Kong, Canada, the Philippines, Russia, and Spain—allegedly causing 774 deaths.²⁸ The Chinese authorities initially failed to report the new disease to WHO and, in fact, tried to conceal its existence.²⁹ The Chinese government revealed the extent of the epidemic only in March 2003, after mounting media and political pressure, and after the disease was diagnosed in other countries.³⁰ At that time, it allowed a WHO team to enter its territory and assess the situation for the first time.³¹ By that point, the alarm caused by a new, unknown disease had already spread worldwide, and WHO had issued a global alert for the disease.³² WHO was also able to release daily updates describing the progress of the epidemic and controlling

26. These include UNICEF, UNDP, OCHA, the European Commission Humanitarian Office (ECHO), US Aid International Development Office (“USAID”), Medicines Sans Frontières, Oxfam, and many others. Their programs, often carried out jointly, typically include the establishment of field health clinics and monitor centers, mother-and-child care, provision of water and food, vaccination and sanitation campaigns.

27. See A SAFER FUTURE, *supra* note 10, at 66.

28. See D. FIDLER, SARS, GOVERNANCE AND THE GLOBALIZATION OF DISEASE (2004); *Severe Acute Respiratory Syndrome (SARS)*, A.D.A.M. MED. ENCYCLOPEDIA, <http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0004460> (last visited July 17, 2013).

29. See Yanzhong Huang, *The SARS Epidemic and Its Aftermath in China: A Political Perspective*, in LEARNING FROM SARS: PREPARING FOR THE NEXT DISEASE OUTBREAK (Stacey Knobler et al. eds., 2004), available at: <http://www.ncbi.nlm.nih.gov/books/NBK92479/> (asserting that “the public was kept uninformed about the disease. According to the Implementing Regulations on the State Secrets Law regarding the handling of public health-related information, any occurrence of infectious diseases should be classified as a state secret before they are “announced by the Ministry of Health or organs authorized by the Ministry.” In other words, until such time as the Ministry chose to make information about the disease public, any physician or journalist who reported on the disease would risk being persecuted for leaking state secrets . . . A virtual news blackout about SARS thus continued well into February [2003]”).

30. *Id.*

31. *Id.* (stating “WHO experts were invited to China by the Ministry of Health but were not allowed to have access to Guangdong until April 2 [2003]”).

32. See *Global Alert and Response (GAR)*, WORLD HEALTH ORG., <tp://www.who.int/csr/don/archive/country/chn/en/> (last visited July 17, 2013).

efforts with the support of reports from national health monitor systems and several governments.³³ WHO issued a travel alert discouraging travel to several countries in Asia and to Canada, where the virus had already been diagnosed and resulted in casualties. WHO's vigorous and coordinated response bore fruit, and by the beginning of July, the epidemic had been stopped.³⁴

The reactions to the SARS epidemic are instructive for several reasons. On the one hand, the initial mishandling of the epidemic by the Chinese authorities demonstrated the need for coordinated intervention by international actors in situations of global health emergencies. China's response revealed the limitations of the existing emergency control system. In fact, had China declared the emergency sooner, the result of the epidemic would have been far less serious, and effective control measures could have been implemented much earlier. Instead, China designated any news relating to the epidemic as State secrets and denied access to outside actors, including WHO and the media, for several crucial months.³⁵ This not only aggravated the situation, but also epitomized the limitation of the international legal system, where little action is allowed without State consent.

On the other hand, the SARS example also provides some positive lessons. First, the international reaction to the spread of SARS demonstrated that WHO has the ability to successfully manage and control a potential global crisis. Second, it proved that the international community as a whole can exercise pressure and show cohesion when needed. Indeed, information related to the outbreak was reported by individuals and non-governmental groups, which alerted other actors in the international community.³⁶ WHO then verified the reports and requested more information from the Chinese government.³⁷ Moreover,

33. *Id.*

34. M. Poulin, *La Gestion par l'OMS des Situations d'Urgence de Portée Internationale. L'exemple du Syndrome Respiratoire Aigu Sévère*, ACTUALITÉ ET DROIT INT'L (Nov. 2003), available at www.ridi.org/adi.

35. See Huang, *supra* note 29, at 3 (stating "WHO experts were invited to China by the Ministry of Health but were not allowed to have access to Guangdong until April 2 [2003], 8 days after their arrival.").

36. *Id.* at 4 (stating "Starting on February 11, the Western news media began to aggressively report on SARS in China and the government's cover-up of the outbreak. On March 15 [2003], the WHO issued its first global warning about SARS. While China's government-controlled media was prohibited from reporting on the warning, the news circulated via mobile phones, e-mail, and the Internet. On March 25, 3 days after the arrival of a team of WHO experts, the government for the first time acknowledged the spread of SARS outside of Guangdong.").

37. *Id.*

once the epidemic was confirmed, WHO issued several global alerts, including travel warnings.³⁸ This was the first time that such restrictions were imposed, and although WHO did not have a clear mandate to issue such alerts, Member States generally complied with them.³⁹

III. HEALTH SYSTEMS IN FAILED AND FAILING STATES

The SARS epidemic crystallized the consensus within the international community that public health emergencies require common action. This is particularly necessary in failed and failing States, where the threats to the population brought by the spread of viruses, the emergence and re-emergence of diseases, and the international security implications of health emergencies are magnified.⁴⁰

Many developing countries struggle in their efforts to ensure appropriate health standards for their citizens. The conditions of national public health systems, especially in certain low-income and highly indebted countries, have improved little in the last fifty years.⁴¹ In most developing countries, social and environmental conditions benefit opportunistic microbes.⁴² Further, several diseases are becoming drug-resistant, including diseases such as tuberculosis and malaria, which have developed antimicrobial resistance.⁴³ As a consequence, public

38. See *Global Alert and Response (GAR)*, WORLD HEALTH ORG., [tp://www.who.int/csr/don/archive/country/chn/en/](http://www.who.int/csr/don/archive/country/chn/en/) (last visited July 17, 2013).

39. See David P. Fidler, *Development Involving SARS, International Law, and the Infectious Disease Control at the Fifty-Sixth Meeting of the World Health Assembly*, ASIL INSIGHTS, June 2003 (note that despite the Canadian government's objection, Toronto was included on the list of places where travel was discouraged).

40. See WORLD HEALTH ORGANIZATION, *THE WORLD HEALTH REPORT 2003—SHAPING THE FUTURE* ix, (2003) available at <http://www.who.int/whr/2003/en/> (noting that “[g]lobal health is a study in contrasts. While a baby girl born in Japan today can expect to live for about 85 years, a girl born at the same moment in Sierra Leone has a life expectancy of 36 years”).

41. For example, in Somalia, the mortality rate of under-five-years-old children remained unchanged between 1983 and 2011 (180 per 1,000 live births). *Mortality Rate, Under-5*, WORLD BANK, <http://data.worldbank.org/indicator/SH.DYN.MORT/countries/1W-SO?display=graph> (last visited July 17, 2013).

42. David D. Fidler, *The Globalisation of Public Health: Emerging Infectious Diseases and International Relations*, as quoted in FIDLER, *supra* note 3, at 22. Fidler identifies the following parts for the pathology for the globalization of public health in the era of emerging infectious diseases: “1. international trade and travel as effective channels for infectious diseases spread; 2. deteriorating or nonexistent public health capabilities, including the declining effectiveness of antimicrobial drugs; 3. the failure of the internationalization of public health; 4. the development of unprecedented levels of deeply rooted social, economic, and environmental problems that provide pathogenic microbes with fertile conditions.” *Id.*

43. See *Multidrug-Resistant Tuberculosis*, *supra* note 12.

health systems in developing countries remain inadequate and often incapable of coping with health emergencies, such as epidemics and the discovery of new infectious diseases.⁴⁴

The situation of failing and failed States is particularly daunting. Failed States are characterized by an implosion of State structure, which results in the incapability of governmental authorities to perform their functions, which include providing security, respecting the rule of law, exercising control, supplying education and health services, and maintaining economic and structural infrastructures.⁴⁵ Failed States are, by definition, unable to provide basic political and social goods to their people. Often, their health care systems are all but collapsed.⁴⁶ Moreover, the spread of disease and new epidemics cannot be properly monitored and controlled.⁴⁷ One of the defining characteristics of State failure is a State's growing inability to provide basic health care, which results in a decline in health indicators like infant mortality and life expectancy.⁴⁸ Based on this definition, former WHO Director-

44. WHO further affirms: "Newly recognized and familiar pathogens have reasserted their epidemic potential as: 1. Development gaps have widened, leaving many countries unable to provide adequate basic services such as safe water, adequate nutrition, waste disposal and health care for their populations. 2. Governmental and public health care systems in many countries have collapsed due to civil strife and war. 3. Poverty, urbanization and population displacement have led to concentration of human populations in conditions that favour major outbreaks (e.g. refugee camps, urban slums). 4. Exploitation of pristine environments is exposing human populations to new infectious agents. 5. Diseases within animal populations cross into human populations. 6. Environmental change may alter the endemicity and transmission patterns of pathogens. 7. Ineffective vector control programmes have led to a proliferation of vectors, including resistant vector populations. 8. The development of antimicrobial resistance now threatens to make once curable diseases incurable. 9. The potential for accelerated spread of disease has increased markedly with globalization of travel and trade. 10. The situation is further compounded by inappropriate social, political and economic responses to epidemics with implementation of misguided measures to control disease spread." WHO Dep't of Communicable Disease Surveillance and Response, *A Framework for Global Outbreak Alert and Response*, WHO/CDS/CSR/2000.2, at 1, available at <http://www.who.int/csr/resources/publications/surveillance/whocdscsr2002.pdf>.

45. State failure results from several interlinked causes, both endogenous and exogenous to the State. Endogenous causes include corruption, structural weaknesses, and misadministration. Exogenous causes include macroeconomic and political policies, foreign interventions either in support of those in power or opposition groups, or decline of foreign financial and political support. For an overview of State failure and international law, see GIORGETTI, *supra* note 2.

46. For relevant health data, see *Mortality Rate, Under-5*, WORLD BANK, <http://data.worldbank.org/indicator/SH.DYN.MORT/countries/IW-SO?display=graph> (last visited July 17, 2013).

47. See Robert I. Rotberg, *The New Nature of Nation-State Failure*, WASH. Q., Summer 2002, at 85.

48. See *id.*; see also Collapsed States, *The Disintegration and Restoration of Legitimate Authority* (I. William Zartman ed., 1995).

General, Doctor Gro Brundtland, suggests that almost a third of the population of sub-Saharan Africa lives in countries that can be defined as weak and failed States, or that are ravaged by complex emergencies.⁴⁹

The consequences of State failure on public health emergencies are important. Failed States become reservoirs for diseases that can spread internationally, yet they are unable to cope with disease outbreaks because they lack a working health system that can appropriately sustain public health functions, prevent disease outbreaks, participate in disease eradication programs, and create conditions to reduce disease transmission and promote health for all. Further, diseases spread more easily as a result of a reduced effort and ability to control them. Dr. Brundtland took Ebola as an example and suggested that:

So far it has been contained because it has been confined to small villages far from big cities. Health systems like that of Uganda have done a fine job in isolating patients and restricting spread. They could do this with the help of international specialists from WHO and [the Centers for Disease Control in] Atlanta because the security situation in the area was good. What if an outbreak takes place in a devastated Central African country where there is no local health care? What if the security situation was so bad that we could not send in international experts to advise and assist in containing the outbreak? What if infected people start fleeing into cities, to neighboring countries, and eventually out of the region?⁵⁰

It is indeed the risks that Dr. Brundtland envisages that need to be addressed. What can be done if an international health emergency occurs in a State that is incapable of controlling or dealing with it?

Health emergencies in failed States are problematic not only for the particular States and their populations. They also present risks and challenges for the entire international community, which needs to be able to actively and effectively address global emergencies. It is therefore particularly important to assess the mechanisms that already exist and that can be usefully employed in response. At the same time, it is important to identify possible lacunae that need to be filled to face possible emergencies.

49. See Brundtland, *supra* note 13, at 4.

50. *Id.* at 5.

Few strategies exist to support the health systems of failed and failing States, both at the international and national levels. Internationally, several international organizations have been mandated to address specific aspects of international health emergencies.⁵¹ Among these, WHO plays the main role in addressing public health emergencies. The role of WHO and of the international community in addressing public health emergencies is analyzed and appraised in the remaining sections of this Article. First, the Article addresses the role of WHO, and specifically two WHO mechanisms that address health emergencies in failed and failing States: IHR 2005 and GOARN. Next, the Article explores mechanisms that other international organizations, such as UNICEF and OCHA, adopt to provide support in global health emergencies.

IV. THE ROLE OF WHO IN ADDRESSING GLOBAL HEALTH EMERGENCIES

WHO, the principle international organization dealing with global health, was created on April 7, 1948, and soon thereafter became the specialized UN agency for health issues.⁵² WHO has 194 Member States and thus enjoys virtual universal membership.⁵³ The WHO Constitution provides no mechanisms of withdrawal and no expulsion mechanisms against Member States that do not behave according to its Constitution.⁵⁴ The main governing body of WHO is the World Health Assembly, composed of delegates representing Member States. Additionally, the governing structure of WHO also includes a 34-member Executive Board elected by the World Health Assembly for a period of three years, a Secretariat headed by a Director-General, and *ad hoc* committees established by the Executive Board following a proposal by the World Health Assembly or the Director-General.⁵⁵

51. These include WHO, UNICEF, and the World Bank. Nationally, several donor countries include funding for health emergencies in their emergency and humanitarian programs, which are mostly channeled through international organizations, like WHO, UNICEF, and other UN agencies. See Paeslee, *supra* note 24.

52. See generally G. L. BURCI & C-H. VIGNES, *WORLD HEALTH ORGANIZATION* (2004); C-H. Vignes and H. J. Schelzka, *World Health Organization*, in 4 *ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW* 1, 406-09 (Bernhardt ed., 1981); A. J. Paeslee, *World Health Organization*, in 3 *INTERNATIONAL GOVERNMENTAL ORGANIZATIONS CONSTITUTIONAL DOCUMENTS* 449-51 (rev. 3d. ed., 1979); *WORLD HEALTH ORGANIZATION*, www.who.int. (last visited July 17, 2013).

53. *Countries*, *WORLD HEALTH ORG.*, <http://www.who.int/countries/en/> (last visited July 17, 2013).

54. BURCI & VIGNES, *supra* note 52.

55. *Governance*, *WORLD HEALTH ORG.*, <http://www.who.int/governance/en/index.html> (last visited July 17, 2013).

On a global scale, WHO

plans and coordinates health actions on a global basis. At the request of members, it assists them in planning and carrying out health programs, strengthening their health services and training health workers. It promotes medical research and exchange of scientific information [and] makes health regulations for international travel, keeps communicable disease under constant surveillance, collects and disseminates data on health matters and sets standards for the quality control of drugs, vaccines, and other substances affecting health. It gives health assistance to members in emergencies or natural disasters.⁵⁶

WHO's stated objective is "the attainment by all peoples of the highest possible level of health,"⁵⁷ defined in the preamble of its Constitution as "a state of complete physical, mental and social well-being."⁵⁸ Its role in global health emergencies is therefore fundamental. In fact, health is a dynamic concept and an "intrinsically complex and multi-faced topic, which straddles many areas of human activity and which has undergone a deep technical and philosophical evolution during the last few decades."⁵⁹

To reach its objective, WHO has both normative and directing powers.⁶⁰ WHO can, *inter alia*, act as a coordinator and coordinating authority on international health work. Upon request, it assists governments in strengthening health services, and it facilitates the UN's provision of health services and assistance to special groups, such as the peoples of trust territories.⁶¹ Further, WHO can stimulate and advance work to eradicate epidemics, endemics, and other diseases; provide information, counsel, and assistance in the field of health; standardize

56. Peaslee, *supra* note 52, at 450.

57. Constitution of the World Health Organization art. 1 [hereinafter WHO Constitution], available at <http://apps.who.int/gb/bd/PDF/bd47/EN/constitution-en.pdf>.

58. *Id.*

59. BURCI & VIGNES, *supra* note 52, at 108. Health is also interlinked to many other basic issues, which are at the center of the international agenda, including economic and social development, human rights, children and women's rights, environment and food policies.

60. "Normative powers" refer to the power to approve, through the World Health Assembly, specific regulations that are mandatory for Member States. By contrast, WHO's "directing powers" encompass policy directives that suggest, but do not require, that Member States undertake a certain course of action. *See id.*

61. WHO Constitution, *supra* note 57, at art. 2(e).

diagnostic procedures; and generally take all necessary action to attain its objective.⁶²

WHO Member States have explicitly recognized the link between health and global security. In 2001, the World Health Assembly approved an important resolution on Global Health Security, which recognized that “any upsurge in cases of infectious disease in a given country is potentially of concern for the international community.”⁶³ The resolution highlights a three-part strategy to address “global health security”: (1) the development of specific programs for the prevention and control of known epidemic threats, such as influenza, meningitis,

62. *Id.* at art. 2. The Article enumerates the functions of the Organization. The full Article states: “In order to achieve its objective, the functions of the Organization shall be: (a) to act as the directing and co-ordinating authority on international health work; (b) to establish and maintain effective collaboration with the United Nations, specialized agencies, governmental health administrations, professional groups and such other organizations as may be deemed appropriate; (c) to assist governments, upon request, in strengthening health services; (d) to furnish appropriate technical assistance and, in emergencies, necessary aid upon the request or acceptance of governments; (e) to provide or assist in providing, upon the request of the United Nations, health services and facilities to special groups, such as the peoples of trust territories; (f) to establish and maintain such administrative and technical services as may be required, including epidemiological and statistical services; (g) to stimulate and advance work to eradicate epidemic, endemic and other diseases; (h) to promote, in co-operation with other specialized agencies where necessary, the prevention of accidental injuries; (i) to promote, in co-operation with other specialized agencies where necessary, the improvement of nutrition, housing, sanitation, recreation, economic or working conditions and other aspects of environmental hygiene; (j) to promote co-operation among scientific and professional groups which contribute to the advancement of health; (k) to propose conventions, agreements and regulations, and make recommendations with respect to international health matters and to perform such duties as may be assigned thereby to the Organization and are consistent with its objective; (l) to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment; (m) to foster activities in the field of mental health, especially those affecting the harmony of human relations; (n) to promote and conduct research in the field of health; (o) to promote improved standards of teaching and training in health, medical and related professions; (p) to study and report on, in co-operation with other specialized agencies where necessary, administrative and social techniques affecting public health and medical care from preventive and curative points of view, including hospital services and social security; (q) to provide information, counsel and assistance in the field of health; (r) to assist in developing an informed public opinion among all peoples on matters of health; (s) to establish and revise as necessary international nomenclatures of diseases, of causes of death and of public health practices; (t) to standardize diagnostic procedures as necessary; (u) to develop, establish and promote international standards with respect to food, biological, pharmaceutical and similar products; (v) generally to take all necessary action to attain the objective of the Organization.” *Id.*

63. Global Health Security: Epidemic Alert and Response, WHA 54.14, 54th World Health Assembly, May 21, 2001 [hereinafter Resolution WHA 54.14], available at http://apps.who.int/gb/archive/pdf_files/WHA54/ea54r14.pdf.

or cholera; (2) the detection of and response to health emergencies that result from unexpected circumstances or unknown causes; and (3) improved preparedness through the strengthening of national infrastructures for disease surveillance and response.⁶⁴

Additionally, the resolution specifically requested that the Director-General provide technical support to all Member States to develop intervention programs aimed at preventing epidemics and responding to the threats and emergencies of communicable disease, in particular with regard to epidemiological investigations, laboratory diagnoses, and the management of cases by the community and clinics. The resolution also requested that the Director-General make appropriate arrangements to develop plans for regional preparedness and response. Finally, the resolution urged that the Director-General provide support to Member States to strengthen their capacity to rapidly detect and respond to threats and emergencies related to communicable diseases, especially by "developing the laboratory skills needed for diagnosis and providing training in epidemiological methods for use in the field, particularly in the most exposed countries."⁶⁵

Although under the WHO Constitution, Assembly resolutions are generally not binding legal instruments, the World Health Assembly determines the policies of the organization, and resolutions have a directive function.⁶⁶ Moreover, the strategy envisaged by the resolution is applicable in all health emergency situations and seems to be suited to deal with some situations arising from State failure.

The implementation of the resolution relies on WHO's Epidemic and Pandemic Global Alert and Response Operations (GAR), which is the main operational tool to address global health security.⁶⁷ GAR mainly operates through two important and interlinked instruments: the 2005 International Health Regulations (IHR 2005) and the Global Outbreak Alert and Response Network (GOARN).⁶⁸ The following

64. VIGNES & BURCI, *supra* note 52, at 141.

65. Resolution WHA 54.14, *supra* note 63, ¶ 3.

66. WHO Constitution, *supra* note 57, at art. 18.

67. GAR responds to a series of diseases of international importance including: anthrax, avian influenza, Crimean-Congo hemorrhagic fever, dengue/dengue hemorrhagic fever, Ebola hemorrhagic fever, hepatitis, influenza, Lassa fever, Marburg hemorrhagic fever, Meningococcal disease, plague, Rift Valley fever, SARS, Smallpox, Tularaemia and yellow fever. See *Pandemic and Epidemic Diseases*, WORLD HEALTH ORG., <http://www.who.int/csr/disease/en/> (last visited July 17, 2013).

68. *Alert & Response Operations*, WORLD HEALTH ORG., <http://www.who.int/csr/alertresponse/en/> (last visited July 17, 2013).

sub-sections evaluate the functioning, successes, and challenges of these key public health emergency tools.

A. *The 2005 International Health Regulations Framework*

IHR 2005 is a key instrument for WHO's strategy to address global health security. It can also be an effective tool to assist States, including failing States, in addressing health emergencies and preventing the international spread of infectious diseases. IHR 2005 built on the original IHR and must therefore be placed in its historical context to be properly understood.⁶⁹

1. The Original International Health Regulations

In a rare use of its Article 21 normative powers,⁷⁰ the World Health Assembly initially adopted the International Sanitary Regulations—the predecessor to IHR—by resolution on May 25, 1951.⁷¹ The regulations provided unique powers to WHO to act on specific infectious diseases in all Member States. Article 21 of the WHO Constitution gives the World Health Assembly unique normative powers to regulate international disease control.⁷² Through Article 21, the Assembly can adopt regulations concerning five specific areas, including “sanitary and quarantine requirements and other procedures designed to prevent

69. Historically, international coordinated actions to control the spread of certain infections predated the creation of WHO. In fact, when WHO was established, it inherited the responsibility of controlling the international spread of diseases from a series of international agreements and conventions dating back from the first International Sanitary Conference in Paris in 1851. Between then and the end of the century, eight conventions on the spread of infectious diseases across national boundaries were negotiated, and multilateral institutions were established to enforce these conventions, including the precursor to the present Pan American Health Organization. BURCI & VIGNES, *supra* note 52, at 134-35; *see also* Peaslee, *supra* note 52, at 409-51.

70. Article 21 has only been used twice. It was used the first time to adopt the ‘Regulations Regarding Nomenclature’ No. 1, on 22 May 1967. These Regulations deal with the harmonization of statistical classifications of morbidity and mortality by Member States following WHO recommendation for purpose of easier comparability. *See* Resolutions Regarding Nomenclature, 20th World Health Assembly (May 22, 1967), <http://www.who.int/classifications/icd/docs/en/NOMREGS.pdf>.

71. International Sanitary Regulations, WHA 4.75 (May 25, 1951), *available at* http://whqlibdoc.who.int/trs/WHO_TRS_41.pdf.

72. Article 19 of the WHO Constitution also enumerates normative powers of the Health Assembly, which may adopt conventions or agreements in matter for which the organization is competent, such as the recently adopted Framework Convention on Tobacco Control, *available at* <http://www.who.int/tobacco/framework/en/>. *See* WHO Constitution, *supra* note 57, at art. 19.

the international spread of disease."⁷³ Regulations are adopted by a simple majority within the Assembly⁷⁴ and "come into force for all members after due notice has been given of their adoption by the Health Assembly except for such members as may notify the Director-General of rejection or reservations within the period stated in the notice."⁷⁵ Thus, all Member States are bound by the regulations once adopted, provided they have not expressly announced a reservation to them.

Since its creation in 1948, WHO consolidated the diverse conventions relating to public health, and at its Fourth Health Assembly in 1951, adopted the International Sanitary Regulations, which constituted the "only international health agreement on communicable diseases that is binding on Member States."⁷⁶ The regulations declared that they replaced, between the parties, all earlier conventions and agreements.⁷⁷ Their objective was "to ensure the maximum security against the international spread of diseases with a minimum interference with world traffic."⁷⁸ At first, they only covered the so-called "quarantinable diseases."⁷⁹ The regulations were revised several times since 1948, mostly as a result of improved knowledge on epidemic

73. The other areas are: (b) nomenclatures with respect to diseases, causes of death and public health practices; (c) standards with respect to diagnostic procedures for international use; (d) standards with respect to the safety, purity and potency of biological, pharmaceutical and similar products moving in international commerce; (e) advertising and labeling of biological, pharmaceutical and similar products moving in international commerce. *Id.* at art. 21.

74. Article 60 of the WHO Constitution states: "(a) decision of the Health Assembly on important questions shall be made by a two-thirds majority of members present and voting. These questions shall include: the adoption of conventions or agreements; the approval of agreements bringing the Organization into relations with the United Nations and inter-governmental organizations and agencies in accordance with Articles 69, 70 and 72 [all relating to Relations with other Organizations]; amendments to this Constitution. (b) Decisions on other questions, including the determination of additional categories of questions to be decided by a two-thirds majority, shall be made by a majority of the members present and voting. (c) Voting on analogous matters in the Board and in committees of the Organization shall be made in accordance with paragraphs (a) and (b) of this article." *Id.* at art. 60.

75. *Id.* at art. 22.

76. David P. Fidler, *International Law and Infectious Diseases* 58-71 (1999) (citing Fidler, *supra* note 3 at 129).

77. World Health Organization, *International Health Regulations* (1969) (3d ed. 1983) [hereinafter WHO, *International Health Regulations*].

78. *Id.*

79. The quarantinable diseases were: plague, cholera, yellow fever, smallpox, louse-borne typhus, and louse-borne relapsing fever. *Id.*

diseases.⁸⁰ In 1969, the regulations were also renamed to the presently known IHR.⁸¹

Originally, IHR was a unique mechanism to control the international spread of certain human diseases.⁸² It was an international legal instrument that was legally binding on all WHO Member States who had not rejected them or made specific reservations, as well as on all non-Member States that had agreed to be bound by them. Because WHO enjoys quasi-universal membership, IHR was widely applicable. IHR required Member States to notify WHO about any single case of plague or yellow fever occurring in humans in their territories.⁸³ In this context, IHR provided a powerful tool to the World Health Assembly to control the spread of certain epidemics.

However, IHR mechanisms never truly developed the full potential of their legally binding status and did not prove to be effective in controlling the global spread of disease.⁸⁴ First, Member States were reluctant to notify outbreaks of diseases subject to IHR.⁸⁵ Certain Member States feared disproportionate reactions from other WHO Member States and their consequences on trade and tourism.⁸⁶ Others were reluctant because of internal political reasons also linked to a perceived dishonor in experiencing disease outbreaks.⁸⁷ Finally, some Member States simply lacked the necessary surveillance systems required to recognize and report outbreaks under IHR. Second, IHR did not contain any enforcement provisions to ensure compliance.⁸⁸ There are no available sanctions for failure to comply with binding regula-

80. For example, special provisional provisions relating to the Mecca pilgrimage were repealed in 1956. See BURCI & VIGNES, *supra* note 52, at 135. Also, for example, louse-borne typhus and louse-borne relapsing fever were removed from the scope of the list in 1969 because they were not considered to be a risk anymore. Following its eradication, smallpox was also removed from the regulation in 1981. WHO, INTERNATIONAL HEALTH REGULATIONS, *supra* note 77, at 5 (citing Thirty-Fourth World Health Assembly Res. WHA34.13 (May 20, 1981)).

81. *Id.* (citing Twenty-Second World Health Assembly, Res. WHA22.46 (July 25, 1969)).

82. For an instructive overview of IHR, see *Global Capacities, Alert and Response*, WORLD HEALTH ORG., <http://www.who.int/csr/ihr/howtheywork/faq/en/print.html> (last visited July 17, 2013).

83. WHO, INTERNATIONAL HEALTH REGULATIONS, *supra* note 77 ("WHO Member States are obliged to notify WHO for a single case of cholera, plague or yellow fever, occurring in humans in their territories, and give further notification when an area is free from infection.").

84. See D.P. Fidler, *International Law and Infectious Diseases* 133 (1999); see also Burci & Vignes, *supra* note 52, at 137-39.

85. BURCI & VIGNES, *supra* note 52, at 129-35.

86. *Id.*

87. *Id.*

88. See Fidler, *supra* note 3, at 134 (adapted from D. P. Fidler, *International Law and Infectious Diseases* 58-71 (1999)).

tions approved under Article 21 of the WHO Constitution. Similarly, there is no enforcement provision within IHR beyond a dispute resolution mechanism for questions concerning its interpretation or application.⁸⁹ Third, some of IHR's measures proved ineffective in preventing the spread of diseases. In 1968, even the WHO Deputy Director-General himself observed that "the International Sanitary Regulations had failed to contain the international spread of cholera and smallpox—two of the diseases then subject to those regulations."⁹⁰ Fourth, in some cases, Member States overreacted to certain diseases by adopting excessive disease-control measures that were either prohibited by the regulations or not justified under the epidemiological circumstances of the time.⁹¹ For example, in the wake of the AIDS pandemic, some Member States imposed restrictive measures to travelers, such as requiring them to carry certain health documents.⁹² This violates IHR regulations, but given the lack of enforcement provisions, WHO could take no action against these Member States. Fifth, IHR's scope was limited to controlling three diseases: yellow fever, cholera, and plague.⁹³ Member States have been reluctant to include new diseases on the list. In fact, while several diseases were removed from the list of the regulations, no new disease has ever been included.⁹⁴ Historically, this choice was linked to the fact that these diseases are more likely to substantially affect international trade.⁹⁵ Moreover, this choice could also be explained by the fact that IHR was first approved in 1948—and as indicated above, it has older historical roots—when little was known about other diseases that are now significant, and when the movement of people, goods, and pathogens was not as rapid as it is today. Thus, despite its great potential, IHR failed to provide a general effective mechanism to assist the international community in addressing global health emergencies and controlling the spread of disease.

89. WHO, International Health Regulations, *supra* note 77, at 5.

90. Fidler, *supra* note 3, at 133 (reported in D. P. Fidler, International Law and Infectious Diseases 58-71 (1999)).

91. BURCI & VIGNES, *supra* note 52, at 137-39 (for example, these measures included travel restrictions).

92. *Id.* at 138. Fidler also reports as an example of unnecessary health measures taken under IHR, the EU ban on Fish Exports from Countries in East Africa during a cholera outbreak. See FIDLER, *supra* note 3, at 136-39.

93. See *supra* notes 86, 93.

94. For example, louse-borne typhus and louse-borne relapsing fever were removed from the scope of the list in 1969 and following its eradication, smallpox was removed from the regulation in 1981. Reg. WHA34.13 (May 20, 1981).

95. BURCI & VIGNES, *supra* note 52, at 137-39.

The 2001 SARS epidemic highlighted weaknesses in the IHR system and reinforced the need to revamp IHR by, among other things, focusing its provisions on general descriptions of diseases, rather than on lists of named diseases.⁹⁶ In a resolution relating to the revision of IHR and adopted during the SARS emergency, the World Health Assembly urged the Director-General:

To take into account reports from sources other than official notification, to validate these reports [on infectious diseases] according to established epidemiological principles;

To alert, when necessary and after informing the government concerned, the international community to the presence of a public health threat that may constitute a serious threat to neighboring countries or to international health on the basis of criteria and procedures jointly developed with Member States.

To collaborate with national authorities in assessing the severity of the threat and the adequacy of control measures and, when necessary, in conducting on-the-spot studies by a WHO team with the purpose of ensuring that appropriate control measures are being employed.⁹⁷

This recommendation was pivotal, as it recognized the importance of collaborating with non-State actors and the need to assess the adequacy of control measures implemented by national authorities.

2. The 2005 International Health Regulations

Recognizing IHR's limitations, the World Health Assembly requested a revision of the regulations in 1995 by adopting the Resolution on the Revision and Updating of the International Health Regula-

96. The initial central purpose of IHR 2005 was to replace the list of diseases included in the IHR with the concept of "syndrome notification." The technical groups working on the IHR amendments first identified five syndromes that could cover all the diseases considered of public health importance. However, after undertaking a pilot project in twenty-two countries, it was found that syndromes were too difficult to report and could not be linked to pre-determined rules that could properly control the spread of infectious diseases. The syndrome-approach was therefore dropped and different approaches were pursued. *Id.* at 139.

97. Revision of the International Health Regulations, Fifty-Sixth World Health Assembly Res. WHA56.28 (May 28, 2003), available at http://www.who.int/gb/ebwha/pdf_files/WHA56/ea56r28.pdf.

tions.⁹⁸ The resolution aimed at reflecting the significant changes in disease patterns brought about by the emergence and re-emergence of disease, the advancement of medical science, and the changes in communications technology and shipping methods for goods and cargoes since the adoption of the previous version of the IHR in 1969.⁹⁹

Over the next decade, several WHO technical committees and the Committee on International Surveillance of Communicable Diseases worked on the development of a new set of IHR, which were initially adopted in 2005.¹⁰⁰ In June 2007, eighteen months after the notification of its adoption, IHR 2005 became legally binding on all WHO Member States, except for those Member States that have rejected them or have submitted reservations.¹⁰¹ If the World Health Assembly determines that the reservation is compatible with the object and purpose of IHR 2005, and it has not been objected to by at least one-third of the other Member States within six months of its notification, the regulations enter into force for the reserving Member State, subject to the reservation.¹⁰² Non-Member States of WHO may also notify the WHO Director-General that they agree to be bound by the regulations.¹⁰³

States Parties were required to meet the requirements set forth in IHR 2005 as soon as possible, and no later than five years after the regulations' entry into force.¹⁰⁴ The implementation phase was divided into two parts. The first two years, until June 2009, focused on the assessment of existing national structures and resources and a development of national plans of action.¹⁰⁵ The following three years, until June 2012, focused on the implementation of the plans of action,

98. Revision and Updating of the International Health Regulations, Forty-Eighth World Health Assembly, Res. WHA48.7 (May 12, 1995).

99. See BURCI & VIGNES, *supra* note 52, at 139. For an American perspective on the new regulations, see *International Health Regulations: Perspectives from the Region of the Americas*, PAN AM. HEALTH ORG., Aug. 1, 2004, available at <http://www1.paho.org/English/GOV/CD/cd45-12-e.pdf>.

100. For some negotiating insights, see World Health Organization, Regional Office for South-East Asia, The New International Health Regulations Revision Process, SEA/RC56/4 (July 4, 2003); David P. Fidler, *Revision of the World Health Organization's International Health Regulations*, ASIL INSIGHTS, Apr. 2004, available at <http://www.asil.org/insights/insigh132.htm>.

101. Revision of the International Health Regulations, arts. 59, 61, WORLD HEALTH ORG. (May 23, 2005), available at <http://www.who.int/csr/ihr/WHA58-en.pdf> [hereinafter IHR 2005].

102. *Id.* at art. 62.

103. *Id.* at art. 59.

104. *About IHR*, WORLD HEALTH ORG., <http://www.who.int/ihr/about/en/index.html> (last visited July 17, 2013).

105. See *Global Capacities, Alert and Response*, WORLD HEALTH ORG., <http://www.who.int/csr/ihr/capacity/en/index.html> (last visited July 17, 2013).

specifically regarding national surveillance and response systems.¹⁰⁶ During this period, States Parties were also required to implement the required actions at designated airports, ports, and certain ground crossings.¹⁰⁷ In special circumstances, a two-year extension could be obtained, which would be followed by an additional two-year extension in extraordinary situations.¹⁰⁸

The purpose and scope of the regulations, stated in Article 2, are “to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade.”¹⁰⁹ IHR 2005 represents a significant step forward in WHO’s ability to control and prevent health emergencies of an international nature by requiring countries to report certain disease outbreaks and public health events to WHO, and defining the rights and obligations of Member States to report public health events. It also establishes a number of procedures that WHO must follow in its work to support global public health security.¹¹⁰

Importantly, the definition of public health emergency contained in Article 1 is more comprehensive than the one contained in the original IHR. It is identified as “an extraordinary public health event” determined by two concomitant elements. Such an emergency must “constitute a public health risk to other States through the international spread of disease” and “potentially require a coordinated international response.”¹¹¹ This new definition of a public health emergency is of paramount significance. In fact, it addresses one of the main problems of the original IHR—i.e., its closed-list character—and it extends the application of IHR 2005 to a wide range of diseases, including those that are presently unknown. This definition covers all existing, new, and re-emerging diseases, including emergencies caused by non-

106. *Id.*

107. *Id.*

108. *About IHR*, WORLD HEALTH ORG., <http://www.who.int/ihr/about/en/index.html> (last visited July 17, 2013). The World Health Assembly reviewed the status of implementation of the IHR in its last general meeting in May 2012, finding that several Member States require further implementation actions. *International Health Regulations (2005)—Summary of 2011 State Parties Report on IHR Core Capacity Implementation*, WORLD HEALTH ORG, Doc. WHO/HSE/GCR/2012.10, available at http://www.who.int/ihr/publications/WHO_HSE_GCR_2012.10_eng.pdf

109. IHR 2005, *supra* note 101, at art. 2.

110. *What Are International Health Regulations?*, WORLD HEALTH ORG. (Apr. 8, 2008), <http://www.who.int/features/qa/39/en/index.html>.

111. IHR 2005, *supra* note 101, at art. 1.

infectious disease agents. As such, it significantly enlarges the applicability of IHR, and thus overcomes one of the most important limitations of the original IHR, which was previously applicable only to three determined diseases.

Moreover, the definition relies on two issues that have a large potential impact on the efficient coordination of responses in failed or failing States. First, a "public health emergency" must pose a risk to other States. Thus, the cross-boundary character of present-day health emergencies has become a central feature of IHR 2005. IHR 2005 is only applicable if the disease has the potential to spread internationally and poses a risk to other States. Second, the new definition also recognizes that a health emergency requires an international coordinated response. This is further recognition that, increasingly, States cannot cope by themselves in health emergencies and need to coordinate a response together.

Furthermore, to analyze the relevance of an event as an international public health risk, a series of factors must be considered. These include geographical setting, time, size of the outbreak, closeness to an international border or airport, speed of spreading, and mode of transmission. Article 12 provides the criteria by which the Director-General of WHO may, in consultation with the State Party concerned, determine the existence of a health emergency of international concern.¹¹²

Annex 2 of the regulations provides States with an important decision instrument (a "decision tree" or algorithm) to assess events occurring in their territory.¹¹³ The "decision tree" contains four criteria: the seriousness of the public health impact of the event; the unusual or unexpected nature of the event; the risk of spread internationally; and/or the risk that restrictions to international travel or trade may result because of the event.¹¹⁴ The occurrence of certain diseases, such as SARS, polio, and yellow fever, needs to be reported directly.¹¹⁵ However, when other unspecified and unknown diseases are found, the decision instrument is used.¹¹⁶

Once the conclusion is reached that the event qualifies as an

112. *Id.* at art. 12.

113. International Health Regulation (2005), Annex II Decision Instrument for the Assessment and Notification of Events that May Constitute a Public Health Emergencies of International Concern, WHA58.3, available at <http://www.who.int/csr/ihr/WHA58-en.pdf>; IHR 2005, *supra* note 101, at Annex II.

114. *Id.*

115. *Id.*

116. *Id.*

international public health risk, the State must notify WHO.¹¹⁷ On the basis of the information received, the Director-General of WHO determines whether the event constitutes a public health emergency of international concern.¹¹⁸ If the State Party in whose territory the event is taking place is in agreement with the determination, the Director-General can then seek the views of a special Emergency Committee for appropriate temporary recommendations.¹¹⁹ If the State Party does not agree within 48 hours, the Emergency Committee hears the views of the State Party and makes recommendations to the Director-General, who is responsible for the final decision.¹²⁰ Thus, in addition to providing mechanisms that bolster WHO's ability to control and prevent international health emergencies, the new framework is also a significant step forward in terms of applying legally binding measures to international situations that qualify as health emergencies and that can become a public risk.

The new regulations require all States to notify WHO of any event that may constitute a public health emergency of international concern within twenty-four hours of the event.¹²¹ Importantly, States must respond to WHO's requests for verification of information regarding health emergency events so that appropriate technical collaboration in such emergencies can be ensured and, if necessary, other States can be informed of the public health risks which may require their attention.¹²²

Further, each State is required to establish national IHR focal points to ensure continuous contact with WHO, which must be known to all States.¹²³ In the event of a health emergency, States must respond to public health risks that might spread internationally.¹²⁴ States must also provide the public health rationale and scientific justification for any additional measures that significantly interfere with international traffic.¹²⁵

WHO Member States have also agreed to provide routine inspection and control activities at international airports, ports, and some ground

117. *Id.*

118. IHR 2005, *supra* note 101, at art. 12.

119. *Id.* at arts. 12, 48.

120. *Id.* at arts. 12, 49.

121. *Id.* at art. 6.

122. *Id.* at art. 10.

123. *Id.* at art. 4.

124. *Id.* at art. 15.

125. *Id.* at art. 43.

crossings, to prevent international disease transmission.¹²⁶ States are, furthermore, bound to develop, strengthen, and maintain the capacity to detect and report health emergencies, as defined by IHR 2005.¹²⁷

Fundamentally, the new regulations enhance WHO's role in global health emergencies. In the event of an emergency, WHO itself may recommend measures to be adopted by States affected by a public health emergency of international concern, other States, and operators of international transport.¹²⁸ WHO can also assist all Member States in assessing and controlling outbreaks, thus increasing the credibility of each Member State's response.¹²⁹

WHO may make temporary recommendations on an *ad hoc*, time-limited, risk-specific basis.¹³⁰ WHO can also produce standing recommendations, which indicate the appropriate measures to be applied for specific ongoing public health risks at certain international airports, ports, and ground crossings for routine or periodic application. These can be directed at persons, baggage, cargo, containers, ships, aircraft, road vehicles, goods, or postal parcels.¹³¹

The effectiveness of IHR 2005 was put to the test during the 2009 H1N1 flu pandemic, the first Public Health Emergency of International Concern (PHEIC). H1N1 is a novel strain of influenza A virus, which first emerged in Mexico in March 2009.¹³² The virus quickly spread to 46 countries and caused more than 90 deaths.¹³³ The Director-General of WHO determined that the H1N1 outbreak constituted a PHEIC on April 25, 2009, as provided by IHR 2005.¹³⁴ The Director-General convened an Emergency Committee and consulted the affected States.¹³⁵ The Emergency Committee was tasked with proposing the issuance, modification, extension, or termination of

126. *Id.* at arts. 19, 20, Annex I.

127. *Id.* at art. 13.

128. *Id.* at arts. 12, 15.

129. *Id.* at art. 12.

130. *Id.* at art. 15.

131. *Id.* at art. 16.

132. V. Trifonov et al., Geographic Dependence, Surveillance, and Origins of the 2009 Influenza A (H1N1) Virus, 361 NEW ENG. J. MED. 115-19 (2009).

133. Rebecca Katz, *Use of Revised International Health Regulations During Influenza A (H1N1) Epidemic*, 2009, CTRS. FOR DISEASE CONTROL & PREVENTION, Aug. 2009, http://wwwnc.cdc.gov/eid/article/15/8/09-0665_article.htm.

134. *Id.*; see also *Global Alert and Response: Influenza A (H1N1)—Update 38*, WORLD HEALTH ORG. (May 25, 2009), http://www.who.int/csr/don/2009_05_25/en/.

135. Katz, *supra* note 133.

measures to mitigate the consequences of the PHEIC.¹³⁶ The Emergency Committee met frequently and continuously shared information with national IHR focal points and Member States, which by and large followed WHO's recommendations.¹³⁷ A Review Committee was established to review the implementation of the new IHR 2005 in the H1N1 crises.¹³⁸ It concluded that IHR 2005 advanced the protection of global health and helped the world to better prepare for public health emergencies, and that WHO generally performed well during the pandemic.¹³⁹ The Committee concluded, however, that the world was still "ill-prepared to respond to a severe influenza pandemic or to any similarly global, sustained and threatening public-health emergency."¹⁴⁰ Importantly, the Committee concluded that "the most important structural shortcoming of the IHR is the lack of enforceable sanctions" because there are no legal consequences if a country fails to act or does not explain why it adopted measures that were different from those recommended by WHO.¹⁴¹

IHR 2005 undoubtedly represents a major step forward in controlling the global spread of disease. The double-pronged definition of international health emergency is important: it can encompass all international threats and is based on the risk that it may cause to other States. It is also important that one of the definition's requirements is that the outbreak potentially necessitates a coordinated international response. This highlights the importance of a common reaction. Moreover, States must nominate focal points and must respond to WHO's requests for information on possible health emergencies. The Director-General's power to issue temporary recommendations is similarly very important and novel.

However, as with any international agreement, IHR 2005 represents a consensus among WHO Member States of a balance between their sovereign rights and a shared commitment to prevent the international spread of disease. The compromise between these conflicting interests permeates the regulations. First, similar to IHR, IHR 2005 does not

136. *Id.*

137. *Id.*

138. Implementation of the International Health Regulations (2005): Report of the Review Committee on the Function of the International Health Regulations (2005) in Relation to Pandemic (H1N1) 2009, WORLD HEALTH ORG, Doc. A64/10, 5 May 2011, ¶¶ 15-25, available at http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_10-en.pdf.

139. *Id.*

140. *Id.*

141. *Id.*

include any enforcement mechanism that may be used against a State that fails to comply with IHR 2005 provisions. Although there are soft mechanisms that may stimulate compliance, there are no mandatory tools to ensure compliance with the regulations.¹⁴² Second, IHR 2005 contains no provisions that allow WHO to act upon an emergency in the absence of State action. Thus, only State Members that already have a working health system will be able to participate fully within the IHR 2005 system. The establishment of national focal points may be relevant, especially coupled with a State's obligation to respond to WHO requests for verification of information regarding health emergency events. However, the absence of enforcement mechanisms undermines the stringency of the rule. Third, IHR 2005 is still only focused on monitoring, rather than intervening in, health situations, and WHO can only issue recommendations for the adoption of measures by the State Party experiencing the public health emergency of international concern or by other States Parties.¹⁴³

Despite these limitations, IHR 2005 also includes three interesting new tools that may be of particular use to failed and failing States. First, in making its assessment of health emergencies, WHO can take into account reports other than notifications or consultations.¹⁴⁴ Such reports are likely to include reports of organizations that are active on the ground, and could probably be useful. Second, before taking action based on such reports, WHO needs to consult and attempt to obtain verification from the State Party concerned.¹⁴⁵ During the verification stage, WHO can offer to collaborate with the State Party concerned in assessing the emergency.¹⁴⁶ If the State Party does not accept the offer of collaboration, WHO may, if the magnitude of the emergency justifies it, share the information with other States Parties, thus

142. Indeed, compliance mechanisms are based on "peer pressure." The WHO notes: "although the IHR (2005) do not include an enforcement mechanism per se for States which fails to comply with its provisions, the potential consequences of non-compliance are themselves a powerful compliance tool. Perhaps the best incentives for compliance are "peer pressure" and public knowledge. With today's electronic media nothing can be hidden for very long. States do not want to be isolated. The consequences of non-compliance may include a tarnished international image increased morbidity/mortality of affected populations, unilateral travel and trade restriction, economic and social disruption and public outrage." *Frequently Asked Questions About the International Health Regulations (2005)*, WORLD HEALTH ORG. 3, available at <http://www.who.int/ihr/about/FAQ2009.pdf>.

143. IHR (2005), *supra* note 101, at art. 15.

144. *Id.* at art. 9.

145. *Id.*

146. *Id.* at art. 10.

allowing them to react.¹⁴⁷ Third, and finally, it is for the Director-General to determine the existence of a global health emergency.¹⁴⁸ The Director-General can also issue temporary recommendations to be implemented by other States also, not only by the State that experiences the emergency.¹⁴⁹

Generally, however, the applicability of the IHR 2005 framework in failed or failing States is likely to be limited. It will depend substantially on how IHR 2005 is implemented and the role that the Director-General will take. In fact, as seen above, Article 15 of IHR 2005 gives the Director-General the power to issue temporary recommendations to act on health emergencies, even in the absence of State approval. Whether and how the Director-General will implement this provision will be of key importance to successfully managing health emergencies in failed and failing States. The remaining issue, however, is that the notification of health emergencies must still originate from Member States.¹⁵⁰

B. *The Global Outbreak Alert and Response Network*

The second instrument created by WHO to deal with global outbreaks of disease is GOARN.¹⁵¹ GOARN is the product of technical collaboration between 110 institutions and networks,¹⁵² known as technical partners, that combine human and technical resources with the goal of rapid identification, confirmation, and response to outbreaks of international importance.¹⁵³ GOARN creates an operational framework that links those with relevant expertise and skills for the purpose of keeping the international community alert of any threat of

147. *Id.*

148. *Id.* at art. 12.

149. *Id.* at art. 15.

150. *Id.* at Annex I.

151. For a description of the Network and of its history, see WHO Department of Communicable Disease Surveillance and Response, *A Framework for Global Outbreak Alert and Response*, WORLD HEALTH ORG. WHO/CDS/CSR/2000.2, available at <http://www.who.int/csr/resources/publications/surveillance/whocdscsr2002.pdf>.

152. Member institutions include WHO and UNICEF, the International Committee of the Red Cross, the International Federation of the Red Cross and Red Crescent Societies; as well as several NGOs, such as Médecins Sans Frontières and the International Rescue Committee, as well as scientific institutions in Member States, regional networks and laboratories. For more information on members, see *Global Outbreak Alert & Response Network*, WORLD HEALTH ORG., <http://www.who.int/csr/outbreaknetwork/en/> (last visited July 17, 2013).

153. *Id.*

outbreaks in order to be prepared to respond.¹⁵⁴ GOARN is a more comprehensive and flexible instrument than the IHR; moreover, it can be applied in conjunction with IHR, as it covers the three original IHR diseases and operates under the new IHR 2005 regime. Furthermore, GOARN complements IHR 2005 by facilitating coordination of global health emergency responses on the ground.

GOARN was derived from WHO's non-binding directing and coordinating powers.¹⁵⁵ GOARN was implemented pursuant to the Global Health Security resolution, in which the World Health Assembly expressed its support for the "collaboration between WHO and all potential technical partners in the area of epidemic alert and response, including relevant public sectors, intergovernmental organizations, non-governmental organizations and the private sector."¹⁵⁶ GOARN also directs the Director-General to provide technical support to all Member States for the development of intervention programs to prevent and strengthen their capacities in responding to threats and emergencies from epidemics and communicable diseases.¹⁵⁷ This resolution is fundamental in the effort to control the spread of diseases. First, it recognizes the importance of collaboration with technical partners, including NGOs. Second, it mandates the Director-General to strengthen WHO's assistance to Member States in matters of epidemic prevention and control. Toward these ends, WHO provides the secretarial service for GOARN, which is guided by a Steering Committee. WHO also coordinates international outbreak response through the use of resources from within the network.

154. *Id.*

155. "Generally, WHO has preferred to set norms or standards by non-binding recommendations which entails a duty of members to report on any action taken." *ENCYCLOPEDIA OF PUBLIC INTERNATIONAL LAW* 409-09 (Bernhardt ed.). The coordinating and directing powers of WHO are enshrined in Article 2 of the WHO Constitution, which affirms that, "in order to achieve its objective, the functions of the Organization shall be: (a) to act as the directing and coordinating authority on international health work." WHO Constitution, *supra* note 57, at art. 2. Article 23 and 62 of the WHO Constitution further give the World Health Assembly the power to issue recommendation and gives Member States the duty to report on their actions with respect to the recommendations. *Id.* at arts. 23, 62. Article 23 reads: "The Health Assembly shall have authority to make recommendations to Members with respect to any matter within the competence of the Organization." *Id.* at art. 23. Article 62 monitors the implementation of the recommendations. *Id.* at art. 62. It states: "Each Member shall report annually on the action taken with respect to recommendations made to it by the Organization and with respect to conventions, agreements and regulations." *Id.*

156. WORLD HEALTH ASSEMBLY, 54.14, ¶ 1(3), available at http://www.amun.org/final/03/WHA_II_1.pdf.

157. *Id.* ¶ 3(4).

1. Key Features of the Global Outbreak Alert and Response Network

One of GOARN's goals is the development of standards for international epidemic response. Through these standards, GOARN strives to combat the international spread of disease outbreaks, including all of the diseases included in the GAR strategy and the three IHR diseases;¹⁵⁸ to ensure that affected States receive appropriate technical assistance rapidly; and to contribute to long-term epidemic preparedness and capacity building. GOARN has agreed on several operational protocols that standardize epidemiological, laboratory, clinical management, research, communications, logistics support, security, evacuation, and communications systems.¹⁵⁹ Additionally, GOARN has developed a set of Guiding Principles for International Outbreak Alert and Response, aimed at "improv[ing] the delivery of international assistance in support of local efforts by partners in the Global Outbreak Alert and Response Network, and seek[ing] to promote the highest standards of professional performance in the field."¹⁶⁰

The Guiding Principles for International Outbreak Alert and Response provide detailed standard operating protocols on how to respond to and evaluate outbreaks of disease of international importance, coordinate field activities, and secure international support.¹⁶¹ They provide that WHO should ensure that outbreaks of potential international importance are rapidly verified and information is quickly shared within the Network. An Operational Support Team should then coordinate a rapid response to the requests for assistance from States affected by the outbreak.¹⁶² Next, the most appropriate experts should reach the field in the least possible time to carry out coordinated and effective outbreak control activities.¹⁶³ This international team is expected to integrate and coordinate activities to support national efforts

158. The diseases included in the GAR strategy are: anthrax, Avian influenza, Crimean-Congo haemorrhagic fever, dengue/dengue haemorrhagic fever, Ebola haemorrhagic fever, hepatitis, influenza, Lassa fever, Marburg haemorrhagic fever, meningococcal disease, plague, Rift Valley fever, SARS, smallpox, tularaemia and yellow fever. See *supra* note 67.

159. *Global Outbreak Alert & Response Network*, WORLD HEALTH ORG., <http://www.who.int/csr/outbreaknetwork/en/> (last visited July 17, 2013).

160. *Guiding Principles for International Outbreak Alert and Response*, WORLD HEALTH ORG., <http://www.who.int/csr/outbreaknetwork/guidingprinciples/en/print.html> (last visited July 17, 2013).

161. *Id.*

162. *Id.*

163. *Id.*

and existing public health infrastructure.¹⁶⁴ The principles also recognize the unique role of national and international NGOs in the area of health, including in the control of outbreaks.¹⁶⁵ Finally, the principles recognize that the GOARN responses will proceed with full respect for ethical standards, human rights, national and local laws, cultural sensitivities, and traditions.¹⁶⁶ These principles are general, but they have been implemented to address disease breakouts in a number of countries, including several failed States. GOARN has lent its support to the delivery of international assistance and to local efforts in Afghanistan, Burkina Faso, Côte d'Ivoire, Ethiopia, Kosovo, Republic of the Congo, Sierra Leone, and Sudan.¹⁶⁷

A key feature of GOARN is the Global Alert and Response Team (GART), which is in charge of assessing the epidemiological significance of any reported outbreak and deciding whether any action is needed. The team is made up of members from WHO Country Offices, WHO sub-regional Response Teams, WHO Regional Offices, the Alert and Response Operations Centre team in Geneva, and disease specialists.¹⁶⁸ Every day, in Geneva, GART deals with reports of possible outbreaks and reports of unknown diseases.¹⁶⁹ Once verified, the reports of disease outbreaks are reported in widely accessible publications.¹⁷⁰

GART developed six criteria to assess the seriousness of the reports for global health: first, whether the disease is unknown; second, the potential for its spread beyond national borders; third, the seriousness of the health impact or of unexpectedly high rates of illness or death; fourth, the potential for interference with international travel or trade;

164. *Id.*

165. *Id.*

166. *Id.*

167. *Global Alert and Response: Containing Outbreaks in the Field*, WORLD HEALTH ORG., <http://www.who.int/csr/alertresponse/field/en/index.html> (last visited July 17, 2013).

168. *Global Alert and Response: Event Verification*, WORLD HEALTH ORG., <http://www.who.int/csr/alertresponse/verification/en/> (last visited July 17, 2013).

169. *Id.*

170. These publications include the WHO Outbreak Verification List (OVL), a weekly publication targeted to public health professionals with information on verified or under-verification diseases outbreaks of international public health importance so that timely actions can be taken; the Disease Outbreak News, which provides public information about officially confirmed outbreaks of international importance; and the Weekly Epidemiological Record, which covers epidemiological information on cases and outbreaks of diseases under the IHR and also on other communicable diseases of public health importance. See *Information Management and Dissemination*, WORLD HEALTH ORG., <http://www.who.int/csr/alertresponse/infomanagement/en/print.html> (last visited July 17, 2013).

fifth, the strength of national capacity to contain the outbreak; and, sixth, whether the disease is a suspected accidental or deliberate release.¹⁷¹

The second and last criteria are especially relevant in situations of health emergencies in failing States. The fact that the seriousness of a report is assessed based on its potential of spreading beyond national borders clearly emphasizes GOARN's focus on global, rather than localized, emergencies. Similarly, the assessment of the strength of national capacity to contain the outbreak signals that WHO anticipates the possibility that the State will be incapable of handling the outbreak and is willing to intervene. Once the seriousness of an outbreak is confirmed, WHO provides targeted technical advice and supplies to the affected States.

2. GOARN's Effectiveness in Global Health Emergencies

Through GOARN, WHO can coordinate investigations and responses to global health emergencies.¹⁷² The SARS outbreak provided an important testing ground for the efficacy of WHO's capabilities. First, the initial unofficial reports of an unknown disease in China were received and verified through GOARN.¹⁷³ Second, GOARN proved to be a readily available instrument to control the epidemics, and the effort to control the epidemics was coordinated in part through GOARN.¹⁷⁴ Its role in successfully dealing with the epidemics was recognized by the health community: in May 2003, the World Health Assembly approved a resolution on SARS, requesting the Director-General "to strengthen the function of WHO's Global Outbreak Alert and Response Network."¹⁷⁵ Moreover, in another resolution approved in the same session, the Assembly requested that the Director-General, in the revision process of IHR, take into account reports from sources other than official notifications and to collaborate with national authorities to assess the adequacy of their control measures.¹⁷⁶ Importantly, these resolutions demonstrate the Assembly's support of GOARN's activities and methodologies.

171. *Global Alert and Response: Event Verification*, WORLD HEALTH ORG., <http://www.who.int/csr/alertresponse/verification/en/> (last visited July 17, 2013).

172. *Id.*

173. *Global Alert and Response: The Operational Response to SARS*, WORLD HEALTH ORG. (Apr. 16, 2003), http://www.who.int/csr/sars/goarn2003_4_16/en/.

174. *Id.*

175. Revision of the International Health Regulations, *supra* note 97, ¶ 2.

176. *Id.*

In 2012, GOARN reported eighty-four alerts.¹⁷⁷ For example, in October 2012, GOARN reported an outbreak of Ebola in the Democratic Republic of Congo. The alert reported forty-nine cases of Ebola in the Democratic Republic of Congo, of which twenty-four were fatal. The report details that

[t]he Ministry of Health . . . continues to work with partners, under the National Task Force to identify all possible chains of transmission of the illness and ensure that appropriate measures are taken to interrupt transmission and stop the outbreak. The task force includes [Médecins Sans Frontières, the International Federation of Red Cross and Red Crescent Societies, US Agency for International Development, US Centers for Disease Control and Prevention, and the United Nations Children's Fund and WHO].¹⁷⁸

The report confirmed that samples were tested by the Uganda Virus Research Institute and that the CDC had established a field laboratory in Isiro, where the cases were reported, in the beginning of the outbreak.¹⁷⁹ The Public Health Agency of Canada also provided support on rapid diagnosis in the field with their mobile laboratory facilities.¹⁸⁰

On the same day, a report was also issued providing updates on the outbreak of cholera in Sierra Leone that had affected twelve of its thirteen districts since the beginning of 2012. The update noted that:

With support from national and international partners and donors, including [UNICEF, Oxfam, British Red Cross, Save the Children, Care, Concern, Médecins Sans Frontières, UK Department of International Development, OCHA, International Rescue Committee, and WHO], the Ministry of Health and Sanitation has scaled up the response particularly in the

177. *Global Alert Response: 2012*, WORLD HEALTH ORG., <http://www.who.int/csr/don/archive/year/2012/en/index.html> (last visited July 17, 2013).

178. *Global Alert and Response: Ebola Outbreak in Democratic Republic of Congo—Update*, WORLD HEALTH ORG. (Oct. 8, 2012), http://www.who.int/csr/don/2012_10_08a/en/index.html.

179. *Id.*

180. *Id.*

areas of coordination of the overall response, surveillance and case management.¹⁸¹

The two cases exemplify the different options available to GOARN members to confirm and react to a disease outbreak. They also confirm the international efforts surrounding attempts to isolate the spread of highly contagious communicable diseases.

Interestingly, GOARN's activities also play a role in the implementation of IHR 2005. For example, at the beginning of May 2008, China reported the outbreak of hand, foot, and mouth disease due to enterovirus 71 in Fuyang City.¹⁸² The outbreak resulted in several thousands of cases, of which about twenty were fatal.¹⁸³ On May 21, 2008, the Chinese Center for Disease Control and Prevention, in collaboration with the WHO Representative Office in China, released a preliminary report on the outbreak, which stated that "[a]s part of the efforts to implement [IHR 2005,] China will further strengthen the early warning system by immediate notification of clustering of clinically abnormal and severe cases, as well as [the] increasing international collaboration and information exchange"¹⁸⁴ made available via GOARN.

GOARN has also shown its viability in failed States, where support from the State is completely lacking. For example, it has dealt with several outbreaks arising out of Somalia, although the security situation raised concerns during its operations. In January 2007, WHO reported that there were 114 suspected cases, including fifty-one deaths, of Rift Valley Fever in Somalia.¹⁸⁵ Several actors were involved in the process of detection, confirmation, and containment: one case was confirmed by laboratory analysis in the Kenyan Institute of Medical Research and the Centers for Disease Control (CDC) International Emerging Infec-

181. *Id.*; *Global Alert and Response: Cholera in Sierra Leone—Update*, WORLD HEALTH ORG. (Oct. 8, 2012), http://www.who.int/csr/don/2012_10_08/en/.

182. The first outbreak report is *Global Alert and Response, Enterovirus in China*, WORLD HEALTH ORG. (May 1, 2008), http://www.who.int/csr/don/2008_05_01/en/index.html. Two further updates were also issued on May 7, 2008, available at http://www.who.int/csr/don/2008_05_20/en/index.html, http://www.who.int/csr/don/2008_05_07/en/.

183. *Id.*; *Global Alert and Response: Enterovirus in China—Update 2*, WORLD HEALTH ORG. (May 21, 2008), http://www.who.int/csr/don/2008_05_21/en/index.html.

184. *Id.*

185. *Global Alert and Response: Rift Valley Fever in Kenya, Somalia and the United Republic of Tanzania*, WORLD HEALTH ORG. (May 9, 2007), http://www.who.int/csr/don/2007_05_09/en/index.html.

tious Program in Kenya.¹⁸⁶ Médecins sans Frontières facilitated the transport of samples, and the WHO country office held training sessions with Somali medical officers on how to detect and contain the disease.¹⁸⁷ However, it was reported that the deteriorating security situation hampered control measures in the affected area.¹⁸⁸

In 2002, Somalia's Ministry of Health reported an outbreak of meningitis, later confirmed by the WHO Collaborating Centre for Reference and Research on Meningococci at the National Institute of Public Health in Oslo.¹⁸⁹ As a result of the outbreak, a crisis committee was set up by the Ministry of Health, the Somali Red Crescent Society, Médecins sans Frontières, UNICEF, and WHO. The committee strengthened surveillance and prepared a mass vaccination campaign.¹⁹⁰ The campaigns vaccinated 67,681 people in the first few weeks.¹⁹¹

Again, on May 2, 2000, WHO reported 2,232 confirmed cases of cholera in certain regions of Somalia.¹⁹² WHO carried out cholera control coordination activities through the cholera task force, whose membership includes UNICEF, Action Contre la Faim Internationale, the International Medical Corps, Médecins sans Frontières, the Coordinating Committee of the Organization for Voluntary Services, and the Somali Red Crescent Society.¹⁹³

These examples demonstrate that GOARN is often able to provide effective assistance in cases of disease outbreak and to control the spread of disease. Although it is based on a voluntary mechanism, GOARN is effective in reporting, managing, and to a certain extent, controlling the spread of disease even in failed States, where health systems are dysfunctional or nonexistent. Moreover, the fact that reports are assessed on the basis of a national health system's capability

186. *Id.*; *Global Alert and Response, Rift Valley Fever in Kenya and Somalia—Update 3*, WORLD HEALTH ORG. (Jan. 31, 2007), http://www.who.int/csr/don/2007_01_31/en/.

187. *Id.*

188. *Global Alert and Response: Rift Valley Fever in Kenya, Somalia and the United Republic of Tanzania*, WORLD HEALTH ORG. (May 9, 2007), http://www.who.int/csr/don/2007_05_09/en/index.html.

189. *2002—Meningococcal Disease in Somalia—Update*, WORLD HEALTH ORG. (Jan. 18, 2002), http://www.who.int/csr/don/2002_01_18/en/print.html.

190. *Id.*

191. *2002—Meningococcal Meningitis in Somalia—Update 1*, WORLD HEALTH ORG. (Jan. 28, 2002), www.who.int/csr/don/2002_01_28/en/index.html.

192. *2000—Cholera in Somalia*, WORLD HEALTH ORG. (May 20, 2000), http://www.who.int/csr/don/2000_05_02/en/print.html.

193. *Id.*

to contain outbreaks ensures that proper action is taken in situations of State failure. However, as highlighted above, deteriorating security situations also play a role in the ability to control the spread of diseases in failed States.

GOARN is a flexible system based on collaboration between national and international health care professionals. The assistance provided by GOARN depends upon the threat that the disease outbreak poses to the international community and to international travel and trade, the knowledge of the specific disease, the seriousness of the health impact, and the viability of the affected national health system. If a State is capable of controlling and reporting disease outbreaks, it will do so. Otherwise, WHO's personnel in the field or other health care professionals may also report the outbreak. WHO can also coordinate the response, if possible, with the competent health ministry.¹⁹⁴ WHO and GOARN may take a larger role insofar as the national authorities do not possess the required expertise and capacity to control the outbreak. This "elastic" solution seems to be particularly fitting for failed States.

Nonetheless, GOARN has some important limitations. The main drawback is that it is based on a voluntary system of coordination and is not a legally binding instrument. This means that it does not contain enforcing measures. Thus, for example, GOARN was powerless during the SARS epidemic until China let the inspection team into its territory.

One can argue, however, that GOARN has been effective in many circumstances precisely because it is based on a loose relationship between different actors, which are not competing against each other. GOARN's strength is based on the fact that its membership is varied, and includes governmental and non-governmental actors and international organizations. Moreover, GOARN's members primarily include health professionals, not politicians or negotiators. As such, it does not threaten to hurt sovereignty sensibilities.

V. OTHER INTERNATIONAL EFFORTS TO ADDRESS GLOBAL HEALTH EMERGENCIES IN SITUATIONS OF HUMANITARIAN CRISES

In addition to the WHO instruments, humanitarian programs provide another broad and general mechanism to support the health systems of failed and failing States. Failed and failing States are often also conflict countries or countries with severe humanitarian needs.

194. See *Guiding Principles for International Outbreak Alert and Response*, WORLD HEALTH ORG., <http://www.who.int/csr/outbreaknetwork/guidingprinciples/en/index.html> (last visited July 17, 2013).

The international community, and particularly the UN, has created important mechanisms of intervention in such situations. Specifically, OCHA and UNICEF are particularly active in health emergencies.

In situations of humanitarian crisis, OCHA, a special office of the UN Secretariat, coordinates all operations by UN agencies that provide health and protective services, food, shelter and other on-the-ground humanitarian assistance in fifty countries in Africa, Asia, Europe, and the Americas.¹⁹⁵ These coordinated interventions have become a fundamental mechanism for delivering health care in failed and failing States, as they provide targeted support to populations in need. Equally, they are a mechanism by which the international community can ensure that certain health standards are maintained.

UNICEF is also active in health emergencies in crisis situations, with several projects on the ground. UNICEF is mandated to ensure the protection of children, and has also created a special program for its activities in "Countries in Crises."¹⁹⁶ The program is specifically targeted toward countries in emergencies that are undergoing a particular critical period. UNICEF's stated goal is to reach the most vulnerable in humanitarian crises, where access to vulnerable populations is often delayed because of inaccessibility, armed combat, or weather conditions.¹⁹⁷ To do so, UNICEF identified five organizational priorities: girls' education, early childhood, immunization, the fight against HIV/AIDS, and protection from violence, abuse, exploitation, and

195. United Nations Office for the Coordination of Human Affairs (OCHA), *This Is OCHA* (2010), available at http://ochanet.unocha.org/p/Documents/OCHA_Brochure_Eng_2012.pdf.

196. UNICEF includes in its countries in crises program the following countries: Afghanistan, Angola, Bangladesh, Benin, Burundi, Caribbean, Central African Republic, Central America, Chad, Colombia, Côte d'Ivoire, DPR Korea, Democratic Republic of Congo (DRC), Eritrea, Ethiopia, Georgia, Ghana, Guinea, Guyana, Haiti, Indian Ocean Tsunami, Indonesia, Iran, Kenya, Liberia, Madagascar, Malawi, Mauritania, Mozambique, Namibia, Niger, Northern Caucasus (Russian Federation), occupied Palestinian territory, Peru, Philippines, Sierra Leone, Somalia, Southern Africa, Sri Lanka, Sudan, Tajikistan, Timor-Leste, Uganda, Venezuela, Zimbabwe. See *UNICEF in Emergencies*, UNICEF, http://www.unicef.org/emerg/index_fieldreports.html (last visited July 17, 2013).

197. UNICEF affirmed that and noted that "the consequences (of such emergencies) are usually devastating, leaving entire communities deprived of the most basic assistance and protection. Most of those who die in wartime, for instance, do not die as a direct result of violence but from the loss of basic health services, food, safe water or adequate sanitation. This is especially true for children. The countries with the highest rates of preventable deaths among children are countries which have experienced protracted periods of armed conflict: India, Nigeria, China, Pakistan, Democratic Republic of Congo, and Ethiopia." *Id.*

discrimination.¹⁹⁸ UNICEF's activities in emergency situations vary. For example, in October 2012, UNICEF announced the expansion of its operations within Syria and in the countries affected by the Syrian crisis to assist with growing needs.¹⁹⁹ UNICEF estimated that there are one million children affected by the conflict inside Syria, and that so far, more than one hundred thousand Syrian children have been displaced to other countries in the region, including Lebanon, Jordan, Turkey, and Iraq.²⁰⁰

Although humanitarian programs cannot provide all of the services of an effective health system, they are important interventions by the international community in crisis countries. These efforts provide preliminary and targeted support to national health systems. They are critical in guaranteeing a minimum standard of health to populations living in situations of State failure. They also provide an opportunity for the international community to monitor the situation of certain health indicators and, if necessary, provide the necessary means to counter possible crises and threats.

VI. CONCLUSION: LESSONS LEARNED AND THE WAY FORWARD

Global public health emergencies have become a major concern and an important part of the security policies of many States. This Article examined the instruments available to the international community to control the spread of infectious diseases and health emergencies, focusing on failed and failing States, which are particularly ill-equipped to combat the spread of disease because their health systems are typically non-functioning.

WHO primarily carries out its role as the main actor in the international arena dealing with health emergencies through IHR 2005 and GOARN. This Article has assessed advantages and limitations of each of

198. *Basic Education and Gender Equality: UNICEF Priorities*, UNICEF, http://www.unicef.org/education/bege_61625.html (last visited July 17, 2013). These priorities are the same in both humanitarian and developmental situations. *Id.* Moreover, UNICEF also developed a Core Commitments for Children in Emergencies (CCCs) specifically targeting children. *See UNICEF in Emergencies & Humanitarian Action: Commitments*, UNICEF, http://www.unicef.org/emerg/index_commitments.html (last visited July 17, 2013).

199. UNICEF, *Syria's Children: A Lost Generation? Crisis Report March 2011-March 2013* (March 2013) [hereinafter UNICEF, *Syria's Children*], http://www.unicef.org/infobycountry/files/Syria_2yr_Report.pdf; *see also UNICEF in Emergencies & Humanitarian Action: UNICEF Required US\$900 million to Meet the Needs of Children and Women Worldwide*, UNICEF (Oct. 17, 2012), http://www.unicef.org/emergencies/index_66202.html.

200. UNICEF, *Syria's Children*, *supra* note 199.

these two instruments. IHR 2005 is an important binding legal instrument, but the lack of an enforcement mechanism threatens to undermine its strength in the absence of State cooperation. GOARN represents a new model of global governance: it is a non-binding collection and verification instrument that involves the collaboration of field personnel from international organizations and NGOs, and has become an effective and powerful mechanism to address global health emergencies. Despite their shortcomings, these instruments have proven to be effective in some situations.

The fundamental question that remains to be addressed is what the international community can do in the absence of State cooperation or capacity to perform. Uniquely, under the new IHR 2005, WHO's Director-General can issue temporary recommendations to respond to a trans-boundary health emergency, even in the absence of Member State agreement. However, IHR 2005 assumes that Member States have the core capacity to report and notify health emergencies through a national focal point. The extent to which GOARN can provide information about health emergencies to the Director-General is key to guaranteeing a coordinated and prompt action in the absence of State control. Used symbiotically, IHR 2005 and GOARN can ensure a coordinated response to health emergencies in failed and failing States. It is key to continue to monitor the situation and to provide WHO with the appropriate tools and support. As always, the devil is in the details.